DENTAL ANESTHETICS

Dental anesthetic is a medication or drug. Although life-threatening or other serious complications from the use of dental anesthetic agents are extremely rare, there are inherent risks. These include, but are not limited to, temporary or permanent numbness, paralysis of facial muscles, bleeding, bruising, and a transient irregular heartbeat. Complications may be more pronounced with other medications that I am now taking. I have completed a medical history, which includes all prescription and recreational medications taken, and I have answered all questions truthfully.

DENTAL SEDATIVES

Sedatives, including nitrous oxide (laughing gas) valium, halcion, or Ativan, may cause drowsiness and lack of awareness and coordination. These effects may be aggravated by the use of alcohol or other drugs. While under the effects of any dental sedative, I agree to avoid consuming alcohol and I agree to take only those medications prescribed by my physician or dentist. I understand and agree not to operate any vehicle or other hazardous equipment or to work until I am fully recovered form the effects of any sedative

X_____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have reviewed a copy of Levison Dental Group's Notice of Privacy Practice.

X_____ Date_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us form obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

LEVISON DENTAL

FINANCIAL POLICY

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

Regarding Non-Insured Patients

Payment in full is due at the time of service unless prior arrangements have been made.

Regarding Insured Patients

The estimated non-insurance portion (co-pay and deductible) for treatment rendered is due at the time of service. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid on your account in 90 days, the balance will be expected in full.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance; however, please understand:

- Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party in that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services *they* will not cover.

We accept cash, check, Visa, MasterCard, and American Express. Information regarding extended payment plans through CareCredit is also available. Returned checks will be subject to an additional fee of $50. After 90 days, all accounts are subject to a Finance Charge of 1.5% of the unpaid balance, which is an Annual Percentage Rate of 18%.
A minimum charge of $50 may also be applied for any missed appointment or appointment not cancelled with a 48 hour notice.

We appreciate your trust and confidence in our office. Our goal is to make your visits as pleasant as possible. If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for any professional services rendered. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agrees to pay for all costs and expenses including reasonable attorney fees. I hereby authorize Levison Dental Group to release information necessary to secure the payments of benefits.

NAME (please print) _____ Date _____
SIGNATURE _____ Date _____
PARENT/GUARDIAN (if minor) _____ Date _____